STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	(A2) W	OLTIFLE CO		COMPL	
AND PLAN	OF CORRECTION	155679	A. BUI	LDING	00	1	
		155079	B. WIN			03/27	12012
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					LSDALE DR		
BETHLE	HEM WOODS NUF	RSING AND REHABILITATION C	ENTE	FORT	WAYNE, IN 46835		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F0000							
	This visit was fo	or the Investigation of	F00	000	The creation and submission		
	Complaint IN00105419.				this Plan of Correction does n		
					constitute an admission by thi		
	Complaint IN00105419-Substantiated.				provider of any conclusion set forth in the statement of	L	
	^	ficiencies related to the			deficiencies, or any violation of	of	
	allegations are c				regulation.This provider		
	anegations are c	11CU 1' 3U7.			respectfully requests that the		
	11 1 1 1 1 7 .	1			2567 Plan of Correction be		
	Unrelated defici	ency is cited.			considered the Letter of Credi		
					Allegation. Based on past sur history and no harm identified		
	Survey date: 3/2	6, 27, 2012			any resident; this facility	ιο	
					respectfully requests a desk		
	Facility number:	: 000260			review in lieu of a post surevy		
	Provider number	r: 155679			revist on or before April 1, 201	12.	
	AIM number: 10	00267820					
	Survey team:						
	Ann Armey, RN	I					
	Zimi Zimey, Ki	•					
	Census bed type						
	SNF/NF: 86	·•					
	Total: 86						
	Census payor ty	pe:					
	Medicare: 13						
	Medicare: 54						
	Other: 19						
	Total: 86						
	Sample: 4						
	These deficienci	ies reflect state findings					
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.						
	i chea in accountin	1100 WILL TIV 1/10/10.4.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Z07311

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155679		ILDING	00		LETED 1/2012	
	PROVIDER OR SUPPLIE	R RSING AND REHABILITATION CE	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
		completed on March 30,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **Z07311**

Facility ID: 000260

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155679	B. WIN			03/27/	2012
					ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	PROVIDER OR SUPPLIER	t.		4430 E	LSDALE DR		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CE	NTE	FORT \	WAYNE, IN 46835		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
F0309	REGULATORY OR 483.25	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
SS=E	PROVIDE CARE WELL BEING Each resident m must provide the services to attair practicable phys psychosocial we	ust receive and the facility encessary care and nor maintain the highest ical, mental, and II-being, in accordance with ive assessment and plan of					
	care.	·	F02	00	50000 11: 11		04/01/2012
		ation, interviews, and	F03	J9	F0309 It is the practice of this provider that all residents		04/01/2012
		ne facility failed to ensure			receive the necessary care an	d	
	staff were aware	of the location of all			services to attain or maintain t		
	suctioning equip	ment and that compatible			highest practicable physical,		
ļ	canisters were re	adily available for use			mental, and psychosocial		
ļ	which resulted in	n delay of suctioning for 1			well-being, in accordance with		
	of 1 resident revi	iewed, who required			comprehensive assessment and plan of care. What corrective		
ļ	suctioning, in a s	sample of 4 residents with			actions will be accomplished for	or	
	the potential to a	ffect other residents who			those residents found to have		
ļ	could potentially	require emergency			been affected by the alleged		
	suctioning. (Re	, , ,			deficient practice: Resident		
ļ		,			number B's progress notes, physicians orders, and reports	<u> </u>	
ļ	Findings include	:			upon re-admission were review by the Director of Nursing and	wed	
		9:15 a.m., during the			entire clinical team. Careplans and resident profiles were		
	· · · · · · · · · · · · · · · · · · ·	the ADON (Assistant			updated with diet change		
	Director of Nurs	ing) indicated Resident			accordingly. All updates are		
	#B required suct	ioning recently and had			available in the clinical record	and	
	been hospitalized	d for aspiration			care assignments are readily available to direct care staff. A	.II	
ļ	pneumonia.				suction equipment and		
					compatible canisters are availa	able	
	The clinical reco	ord of Resident #B was			in multiple facility locations. All		
		6/12 at 11:00 a.m., and			licensed nursing staff are train	ed	
	indicated the resident was admitted to the			and knowledgeable to the location and usage of suction			
	facility with diagnoses including but not				equipment. How other resident	:S	
		ntia, hypertension and			having the potential to be affect		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **Z07311**

Facility ID: 000260

If continuation sheet Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а. вілі	LDING	00	COMPLETED
		155679	B. WIN			03/27/2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			4430 EI	SDALE DR	
BETHLEI	HEM WOODS NUR	SING AND REHABILITATION CE	NTE		VAYNE, IN 46835	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	depression.				by the same deficient practice	
					be identified and what corrective	
	On 3/20/12 at 9:4	50 p.m., nursing notes			actions will be taken:All reside	
		witnessed resident			have the potential to be affected	ed
					by the alleged deficient practice. Licensed nurse in	
		way at 7p. resident (sic)			dining room for all meals. All	
	` ′	feel well. Nursing brso			employees will be notified of a	nv
	, ,	gurgles. PRN brtx.			altered diet or fluid changes via	,
	(breathing treatm	nent) administered.			resident profiles and	
	resident was cou	ghing up clear white			neighborhood meetings.	
	secretions. write	er suctioned resident with			Careplans will be updated to	
	tonsil tip several	pieces of chicken			reflect changes. Education to a	
	•	nt with emesis times 3			nurses was completed on 3/28 by the Director of Nursing and	8/12
		n. resident stated felt			Assistant Director of Nursing.	
					Education included: location of	f
	,	reath). NP (Nurse			suction equipment, proper	
	· ·	fied order received to			assembly of all suction equipm	nent
	` •	ER (Emergency			with return demonstrations,	
	Room). DON (D	irector of			proper pressure setting, where	
	Nursing)/family	notified. resident			additional suction supplies can	
	transported by El	MS (Emergency Medical			found, who to contact if suction supplies need replenished,	1
	Services)"				and the suction instruction	
	ĺ				manual What measures will be	
	The Transfer For	rm, dated 3/10/12 at 8:25			put into place or what systemic	
		ne reason for transfer was			changes will be made to ensur	
	_	of) SOB (Shortness of			that the deficient practice does	
	` •				not recur:The suction machine	
	Breatn) noted po	st choking on dinner."			located in the main dining roor and Auguste's cottage are	П
	0.04145				labeled. The unit manager and	lit
		46 a.m., nursing notes			form was updated to include d	
		ident was admitted to the			monitoring of suctioniong	
	hospital for "dx ((diagnosis) SOB			equipment in all three locations	
	(Shortness of Bro	eath) and aspiration."			ensure all necessary equipments available and functioning	nt
					properly. Education to all nurse	es
	A Modified Barium Swallow Study			was completed on 3/28/12 by		
	Report, done at the Hospital, dated				Director of Nursing and Assista	
	3/13/12, indicate	d Resident #B had			Director of Nursing. Education	

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Event ID: **Z07311**

Facility ID: 000260

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155679	B. WIN			03/27/2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L			LSDALE DR	
DETULEI		SING AND DELIABILITATION OF	TNITE		NAYNE, IN 46835	
DETITLE	HEIN WOODS NOR	SING AND REHABILITATION CI	EINIE	FORT	WATNE, IN 40633	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	recurrent silent a	spiration with the			included: location of suction	
	ingestion of thin	liquids			equipment, proper assembly o	f all
					suction equipment with return	
	The Heavitel Die	sahanga Cummany datad			demonstrations, proper pressu	
	•	scharge Summary, dated			setting, where additional suction	
		d the resident had a			supplies can be found, who to	
	discharge diagno	sis of aspiration			contact if suction supplies nee replenished, and the suction	u
	pneumonia.				instruction manual. All outdate	d
					equipment was removed. Suct	
	On 3/13/12 at 5:0	00 p.m., nursing notes			equipment instructions are with	
		ident returned to the			each suction machine. All new	
					hires will recieve training on	
	facility at 4:30 p.	.m.			location and use of suction	
					machines in addition to skills	
	Physician orders	, dated 3/13/12, indicated			validation already included in t	he
	the resident, who	previously had been on			new hire packet.How the	
		No Added Salt) diet, was			corrective actions will be	
	,	nanical soft diet with			monitored to ensure the deficie	
	1 ^				practice will not recur, i.e., wha	
	nectar thick liqui				quality assurance program will	
	evaluated by spe	ech therapy.			put into place; and by what dath the systemic changes will be	ie
					completed: Daily audits of	
	On 3/26/12 at 12	:30 p.m., the resident			suctioniong equipment in all th	ree
	was observed at	the noon meal. She			locations will be conducted by	
		ed fluids. Resident #B			unit manager to ensure all	
					necessary equipment is availa	ble
		id not cough or choke			and functioning properly and	
	during the meal.				turned into Director of Nursing	
					Data will be submitted to the C	
	On 3/26/12 at 1::	50 p.m., RN #10, who			team if the 100% threshold is r	not
	was working on	3/10/12, at the time of			met, an action plan will be	_
	~	lving Resident #B, was			developed. Quarterly refresher in-services on emergency	
	interviewed. She indicated she was standing at the medication cart in the hall with LPN #11, when Resident #B came out of her room.				equipment will be conducted.	ΔΙΙ
					changes were completed on	/ WI
					3/28/2012 and in-servicing will	be
					an ongoing measure to ensure	
					compliance. Non-compliance	
	RN #10 indicated	d the resident had a			facility policy/procedure may	
	deeper voice and	was "gurgling." The RN			result in disciplinary action and	l/or
	l *		1			I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **Z07311**

Facility ID: 000260

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155679	B. WI			03/27/2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					LSDALE DR	
BETHLE	HEM WOODS NUR	SING AND REHABILITATION C	ENTE	FORT	VAYNE, IN 46835	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE
		ident needed to be			re-education.	
		went to get the suction				
	•	LPN #11 remained with				
	the resident.					
	She indicated she	_				
		the nursing supply closet				
		he hall but the canister				
	_	not fit the machine so				
		lling another nurse (LPN				
	#12), who got a 0	different suction machine				
	from the main di	ning room. RN #10				
	estimated there v	vas about a ten minute				
	delay before they	were able to suction				
	Resident #B with	the second machine.				
	RN #10 indicated	d she was new and, at the				
	time of the incide	ent, she was not aware				
	that their were se	everal suction machines				
	available in the f	acility.				
		-				
	On 3/26/12 at 2:4	45 p.m., LPN #11, who				
		he time of the incident,				
	_	She indicated Resident				
	#B came out of h	ner room, had a frothy				
		her shirt and said she was				
	not feeling well.					
	_	ed she told RN #10 the				
		to be suctioned and RN				
		a suction machine. LPN				
	_	e canister RN #10				
		compatible with the				
	_	so another nurse, LPN				
		action machine from the				
		n. She indicated she was				
		ut a hunk of chicken and				
	avie to suction of	ut a munk of chicken and				

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Event ID: **Z07311**

Facility ID: 000260

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMP	E SURVEY LETED	
		155679	B. WIN			03/27	7/2012
	PROVIDER OR SUPPLIER	SING AND REHABILITATION C	ENTE	4430 EL	DDRESS, CITY, STATE, ZIP COL SDALE DR VAYNE, IN 46835	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	felt like there was throat so she was an evaluation. LPN #11 estimate minutes from the resident needed second suction of LPN #11 indicated Resident #B was turning blue and On 3/26/12 at 6:2 interviewed. LPI the evening superon the cart in the of the incident. It was called to help problems with the She indicated Reand she agreed the suctioning so she machine from the indicated she assemachine and LPI resident.	time later, Resident #B s something still in her seed it took five to ten et time she determined the suctioning until the hachine was obtained. ed, during this time, able to talk, was not had stable vital signs. 20 p.m., LPN #12 was N #12 indicated she was rvisor, but was working Secure Unit at the time PN #12 indicated she p after the nurses had e first suction machine. sident #B was gurgling he resident needed e obtained a suction e main dining room. She embled the suction N #11 suctioned the					
	(Director of Nurs told the nurses ha suction canister by another suction r	sing) indicated she was ad trouble with the but they were able to get machine. The DON ecked the supplies, the					

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Facility ID: 000260

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155679			IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	ETED	
		1000/9	B. WIN			03/27	/2012
	PROVIDER OR SUPPLIER HEM WOODS NUR	SING AND REHABILITATION CI	ENTE	4430 EL	.DDRESS, CITY, STATE, ZIP CODE .SDALE DR VAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	following day, as suction canisters	nd there were plenty of available.					
		etween 9:20 a.m. and apanied by the ADON the oserved:					
	portable suction The suction mac tubing were in a	ng room, there was a machine in a cupboard. hine, cord, canister, and portable canvas tote. perational instructions equipment.					
	suction machine station. There was suction machine drawer. There w	Unit, there was a portable in a drawer at the nurses as no sign indicating the was located in the erer no operational the suction machine.					
	the front of the b suction machine, tubing. An instru	e, by the nurses station at uilding, there was a cord, canister and uction manual was with ine that was enclosed in					
	7 canisters sets the suction mach were also several according to the	upply Closet, there were nat were compatible with ines on the units. There I suction canisters, that ADON, were not the suction machines on					

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Event ID: **Z07311**

Facility ID: 000260

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155679		A. BUI	LDING	00	COMPL 03/27/	ETED	
	PROVIDER OR SUPPLIER	SING AND REHABILITATION C		STREET A	ADDRESS, CITY, STATE, ZIP CODE LSDALE DR WAYNE, IN 46835		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR the units. On 3/26/12 at 9:5 responsible for machines responsible for the cart every day but suction equipment room or on the SO On 3/26/12 at 4:1 responsible for the indicated she continuation manumachines. On 3/26/12 at 10 RN #13 and #14 separately about suction equipment suction equipment suction machine was located in the thought the suction on the crash carts have to ask to be	SING AND REHABILITATION CITATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 50 a.m., the staff person nedical supplies indicated equipment on the crash at she did not check the nt in the main dining necured Unit. 15 p.m., the staff person ne medical supplies ald not find the als for two of the suction 15 a.m. and 12:35 p.m., were interviewed the location of the nt. RN #13 indicated the in the main dining room ne kitchen and RN #14 on equipment was redical supply closet and so but indicated he would sure.	B. WIN	STREET A	LSDALE DR		(X5) COMPLETION DATE
	interviewed sepa p.m., at 4:00 p.m respectively. The had not used the some time and fe from some training	N #15, #16, #17, were rately on 3/26/12 at 1:00 and at 4:10 p.m. enurses indicated they suction equipment in elt they would benefit in regarding the suction equipment.					

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Event ID: **Z07311**

Facility ID: 000260

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155679			A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL 03/27/	ETED
		1.00070	B. WING		ADDRESS, CITY, STATE, ZIP CODE	55/217	
NAME OF	PROVIDER OR SUPPLIE	R			LSDALE DR		
		RSING AND REHABILITATION CE	NTE	FORT V	VAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		relates to Complaint					
	IN00105419.	r					
	3.1-37(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **Z07311**

Facility ID: 000260

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 03/27/2012	
		133079	B. WING	_		03/211	2012
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CEI	NTE		LSDALE DR WAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=D	The facility must environment rem hazards as is poreceives adequa assistance device. Based on observer record review, the a resident's feet with foot rests while be wheelchair. This deficiency are reviewed who has wheelchair in a series. Findings include On 3/27/12 at 9:00 the DON (Direct #E was observed prior to entering resident had sutuleft eye. The DO fell out of his who was returning from the resident's who pushed down the by CNA #18. The had foot rests, but the resident is provided to the resident of the resident's who pushed down the by CNA #18. The had foot rests, but the resident is provided to the resident is the resident is the pushed to	ensure that the resident sains as free of accident sible; and each resident te supervision and es to prevent accidents. Action, interviews and the facility failed to assure were on the wheelchair being transported in the affected 1 of 1 residents and fallen from the ample of 4. (Resident in his wheelchair just the Secured Unit. The resident above and below his N indicated the resident the elchair. The resident and appointment and eelchair was being thall on the secure unit me resident's wheelchair at his left foot was not on was intermittently	F032	23	F0323 It is the practice of this provider to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevaccidents. What corrective actiwill be accomplished for those residents found to have been affected by this deficient practice: An additional position device was placed on w/c ped to ensure residents feet stay properly positioned on w/c foo pedals. CNA # 18 received a performance improvement pla ensuring all fall interventions a being followed. How other residents having the potential be affected by the same defici practice will be identified and what corrective actions will be taken: All residents dependent staff for w/c mobility have the potential to be affected by the alleged deficient practice. All residents using wheelchairs we audited for the need for addition assistance devices. Any reside identified with a need was addressed with careplan updated Education was completed by Director of Nursing and Assistance.	ing als t nare to ent to ent tes. the	04/01/2012

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155679	A. BUII			03/27/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
DETULE		OINO AND DELLABILITATION OF			LSDALE DR		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CEI	NIE	FORT	WAYNE, IN 46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The clinical reco	ord of Resident #E was			Director of Nursing to all nursi	ng	
	reviewed and inc	licated the resident was			staff on 3/27/12 regarding		
	admitted to the f	facility on 2/22/12, with			accidents and supervision with		
		included but were not			focus on w/c safety. A daily au	lait	
	_				tool was initiated to check for placement and function of all		
	innited to, demen	ntia with delusions.			assitance devices.What		
					measures will be put into place	e or	
	,	mum Data Set), dated			what systemic changes will be		
	3/5/12, indicated	the resident required			made to ensure that the deficie	ent	
	extensive assista	nce with transfer,			practice does not recur:		
	locomotion, and	dressing.			Education was completed on		
	,	8			3/27/12 regarding accidents a		
	On 3/20/12 at 7:	20 p.m., nursing notes			supervision with a focus on w/	С	
					safety. A post-test was administered to evaluate		
		(Certified Nursing			effectiveness of education. A		
		ssisting the resident to his			daily audit tool was initiated or	n fall	
	room. The note i	ndicated "While pushing			interventions to check for		
	wheelchair, resid	lent put both feet down			placement and function. This		
	on floor firmly.	Resident fell forward and			audit will be utilized by the nur	se	
	hit head on the fl	loor" The note			managers randomly on all thre		
	indicated the resi	ident sustained a			shifts. Any interventions found		
		his left eye brow and			to be in place will be corrected		
		-			immediately and education will provided. Careplans are audited.		
	was being sent to	o the nospital for			quarterly and with any signification		
	evaluation.				changes to ensure accuracy.	ant	
					Daily rounds to be completed	by	
	The transfer form	n, dated at 3/20/12 at			nurse managers.How the		
	7:26 p.m., indica	ted the resident was			corrective actions will be		
	transferred to the	e hospital.			monitored to ensure the deficient		
		•			practice will not recur; i.e., wha		
	The emergency r	room report dated			quality assurance program will		
	The emergency room report, dated				put into place; and by what da the systemic changes will be	ıe	
	3/20/12, indicated, Resident #E had an 8				completed: A CQI monitoring t	ool	
	cm laceration over the left eye that was				titled Resident Care Rounds w		
	closed with suture and a 0.5 cm laceration				be utilized by DNS/ADNS wee		
	over the left maxillary area that was also				x 4, monthly x 6, and quarterly		
	closed with sutur	re.			thereafter. Data will be submit		
	No other injuries	s were noted.			to the CQI team if the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED				
155679		B. WING 03/27/2012			2012			
NAME OF P	ROVIDER OR SUPPLIEF	3	ADDRESS, CITY, STATE, ZIP CODE					
				4430 ELSDALE DR				
BETHLEI	HEM WOODS NUR	SING AND REHABILITATION CEI	NTE FORT WAYNE, IN 46835					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)		PPROPRIATE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
	On 3/21/12 at 4:12 a.m., nursing notes				100%threshold is not met, an action plan will be developed.			
				Non-compliance with facility				
	indicated the resident returned to the facility.				policy/procedure may result in			
					disciplinary action and/ or			
					re-education.			
	Interdisciplinary Notes, dated 3/21/12 at							
6:52 a.m., indicated "Team recommends								
initiating foot pedals to w/c (wheelchair)								
	at all times and front anti tippers to w/c"							
	The state of the s							
	The fall risk care plan, dated 3/3/12 was							
	updated, on 3/21/12, to include "foot							
	pedals on w/c at all times" and "front anti							
	tippers to w/c."							
	uppers to w/c.							
	On 3/27/12 at 3:20 p.m., The ADON							
	_							
	indicated all staff were being inserviced							
	regarding the safety of residents, who							
	were being transported in the wheelchair.							
	3.1-45(a)(2)							

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